CECANF REPORT: INTRODUCTION
DRAFT 7.3

Note: *The introduction will be preceded by a Letter from the Chairman and a story. Story options include:*

- *Pima-Maricopa (we have completed drafts of 2 Pima-Maricopa stories)*
- *Wichita (draft is done)*
- *Hillsborough County*
- *Or… An out-of-the-box approach that starts with a story about Mitre's work and its impact on airline passenger safety or hospital patient safety, if this approach becomes a central focus of the report.*

The opening section of the Introduction is critical and cannot be written until we know what story we are using and the Commissioners reach consensus about the overall thrust of the final report. However, the lead to the Intro will build off of the first story and may include some or all of the following points:

- *Families are unique and complicated: there are no simple answers in terms of preventing fatalities from abuse or neglect.*
- *There is no vaccine or medicine to prevent these fatalities. But there is hope. Precedents for success exist, both in other industries (e.g., airlines) and in select communities across the country that have already come together to address this crisis.*
- *No community is immune to abuse and neglect or to fatalities that result when maltreatment is not prevented or interrupted.*
- *Public awareness of this problem is typically limited to media reports of fatalities. These often lead to blame, reorganization of child welfare agencies, and firing of Commissioners and/or staff—actions that have had little impact on the overall rate of fatalities over time. (Can use Scott Modell's quote: see pull quotes at end of introduction.)*
- *Congress passed the Protect Our Kids Act to support the development of a more comprehensive national strategy that will truly save lives. The Commission is keeping child deaths in sight in order to prevent them.*

What follows is a draft of remaining sections of the introductory chapter:

A National Crisis

Inconsistent data and definitions of child abuse and neglect make it difficult to estimate the exact extent of the current crisis. The National Child Abuse and

Neglect Data System (NCANDS), the federal government data source, estimates that approximately 1,500 children die from maltreatment each year—more children than die annually from childhood cancer. Most experts believe this count is too low and that a true estimate is closer to 3,000 deaths a year. This means anywhere from four to eight children die each day from abuse or neglect. Most of these children are younger than 4 years old, and the majority of those are infants.

The causes of child maltreatment deaths vary widely, and in many cases, families are not known to the child welfare system prior to a death. This is why the problem is so elusive and why it is so difficult to know where or how to intervene. Most fatalities fall into a large, eclectic category labeled neglect, which includes circumstances as varied as: a lapse in supervision that results in a toddler drowning in a bathtub or swimming pool. Or an infant sleeping with an intoxicated adult who rolls over and suffocates the baby. Or a toddler, too young for school and too far from extended family, whose overwhelmed parents simply escape the community's notice until it is too late.

It is not too late, however, to develop a strategy to prevent these deaths in the future. The opportunities for intervention and reform are just as varied as the causes of death. Child protective services (CPS) often gets blamed if a child dies on their watch. But CPS does not—in fact, cannot—do this work alone. Many potential support systems touch the lives of vulnerable families with young children: from the formal child welfare agency, to pediatricians, law enforcement, mental health and substance abuse treatment providers, child care centers, domestic violence shelters, faith-based institutions, and not least, relatives and neighbors. All have a critical role to play in interrupting the cycle of child fatalities.

Child Abuse and Neglect Fatalities Affect Us All

In this country, we cannot afford to let even one child fall through the cracks. The impact on the child's immediate family is devastating, but the ripples of each life cut short extend well beyond the family and last a lifetime. When deaths are high profile, the center of media attention, the entire community is affected.

Joseluis Morales, a CPS supervisor in Texas, told the Commission that a fatality "is enough to just drop you to your knees. It is stuff that will stick with you your whole life."

When it comes to financial costs, we know more about the economic burden of child abuse and neglect than we do about the cost of fatalities. Child maltreatment affects brain development, which determines how well children learn in school, their ability to graduate and get jobs and contribute to society. Children who survive abusive head trauma face a lifetime of health and developmental problems and a significantly reduced life span, all of which come at a cost to their caregivers and to society. Studies estimate the cost of abuse

and neglect in this country at anywhere from $80 billion (Prevent Child Abuse America) to $124 billion (the Centers for Disease Control).[1] And that is per year.

Children who die are robbed of any chance to grow up and become productive adults. A study published in *Child Abuse & Neglect* estimated that per child, the cost of a fatal assault in 2010 dollars was $14,100 in medical costs and $1,258,812 in lost productivity.[2] The Perryman Group, a Texas economic research and analysis firm, estimated the total cost of fatal maltreatment in 2014 from health expenditures and lifetime lost earnings to be more than $25 billion.[3]

Need a quote from hearings (or elsewhere) re: the social or economic cost of CAN fatalities.

Time for Action: The Creation of CECANF

The federal government has had an eye on prevention of abuse and neglect fatalities for some time. Previous commissions and reports brought the problem to national attention and made specific recommendations. Some of these recommendations have been implemented, but the number of child maltreatment fatalities has not decreased. In fact, NCANDS data from 2001 to 2010 shows a slight *increase* in fatalities over the decade.

With the creation of CECANF, Congress and the President sent a galvanizing message: Build on the lessons and recommendations of the past, but create a new, comprehensive national strategy that will truly make a difference. As a Commission, we take our charge seriously.

We began our work in 2014, crossing the country to hold public hearings in 14 jurisdictions. We heard from child welfare commissioners, pediatricians, and law enforcement officials. We looked at the impact of domestic violence, substance abuse, and mental health on child fatalities. We examined the complexities of classification and definitions of these deaths. We grappled with questions of data reporting, data sharing, and predictive analytics. We met with leaders and staff in jurisdictions that had implemented multidisciplinary approaches aimed at reducing fatalities. We looked at what has worked, and what hasn't. And we examined how other safety-critical industries, such as commercial airlines and

[1] Footnote placeholder: I got the Prevent Child Abuse America stat from Richard Gelles report and the CDC figure from Every Child Matters.

[2] Xiangming Fang, Derek S. Brown, Curtis S. Florence, James A. Mercy. "The Economic Burden of Child Maltreatment in the United States and implications for Prevention," *Child Abuse and Neglect*, February, 2012

[3] The Perryman Group, *Suffer the Little Children: An Assessment of the Economic Cost of Child Maltreatment,* 2014.

hospitals, collect and track data to learn from fatal accidents and prevent them from happening in the future.

[Sidebar: CECANF's Charge]

Congress and the President appointed 12 commissioners and gave them two years to develop recommendations for a national strategy to eliminate child maltreatment fatalities. The charge is broad and includes a focus on the following:

- The use of federally funded CPS and child welfare services to reduce fatalities from child abuse and neglect.
- The effectiveness of the services funded by the federal government
- Best practices in preventing child and youth fatalities
- The effectiveness of federal, state, and local policies and systems aimed at collecting accurate, uniform data on child fatalities
- Barriers to preventing fatalities
- Trends in demographic and other risk factors that are predictive of or correlated with child maltreatment
- Methods of prioritizing child abuse and neglect prevention for families with the highest need
- Methods of improving data collection and utilization

[*End Sidebar*]

Lessons From the Past

Reducing child mortality is not a new concern in this country. It was, in fact, one of the main goals of the U.S. Children's Bureau when it was founded in 1912 as the first federal agency in the world dedicated to the well-being of children. At the time, infant mortality rates were estimated at close to 1 in 10 live births. Like child abuse and neglect fatalities today, infant deaths then resulted from a variety of causes and risk factors. Although there was plenty of concern, solutions were not immediately evident.

The creation of the Children's Bureau brought a central focus of federal responsibility and accountability to the issue. The Bureau's staff began by applying research and improving the methods of measuring infant mortality rates (including a campaign for complete and accurate birth registration records). Some prevention activities focused on changing parent behaviors as personal as how infants were fed and how often they were exposed to sunlight. Other efforts targeted community-wide conditions, such as sanitation, crowded living conditions and pasteurization of milk. Private and volunteer organizations rallied around the cause, working in partnership with the government.

These strategies proved successful. By the turn of the 21st century, infant mortality rates had dropped to just 6.6 per 1,000 births. This means of the 4 million children born in the U.S. each year since 1980, some 26,000 more infants per year get a chance at life today than they would have without improvements made over the last decades. "For middle-class families, lower infant mortality goes to the heart of improving quality of life," wrote Ronald Wirtz, editor of *fedgazette* at the Federal Reserve Bank of Minneapolis.[4]

When society identifies and focuses on a problem, history shows over and over again that we can find a solution. There is more good news to report:

- Sudden Infant Death Syndrome (SIDS) has decreased sharply since the early 1990s, when the American Academy of Pediatrics issued safe sleep guidelines for infants and a group of government and private organizations developed the "back to sleep" public education campaign. Overall rates of SIDS have declined from 130.3 deaths per 100,000 live births in 1990 to 39.7 deaths per 100,000 live births in 2013.[5]
- Although the incidence of childhood cancers has not changed substantially since 1970, the survival rate has improved dramatically. The overall five-year survival rate for childhood cancer is now close to 80 percent.[6]

Child maltreatment fatalities are not caused by a disease, of course, and science alone will not make the difference. But there are lessons to be learned from medical history. Success requires leaders who hold fast to the vision that these deaths can be prevented, just as they did with developing a national strategy against polio, measles or, more recently, Ebola.

Need quote here from one of our hearings about the fact that preventing CAN deaths is do-able.

A Strategy for the 21st Century

A national focus on ending child maltreatment fatalities will include attention on how and when to intervene, strategies to integrate effective practices and communicate across systems, and multidisciplinary approaches to support families and children. As we will show throughout this report and in our

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[4] Wirtz, Ronald, "Supersize me," *fedgazette, September 1, 2008.* https://www.minneapolisfed.org/publications/fedgazette/supersize-me

[5] One subcategory of SIDS, however, is on the radar screen of CECANF and that is accidental suffocation and strangulation of infants in bed, often by a co-sleeping parent or caretaker who is intoxicated or on drugs. In many (?) jurisdictions, these "rollover" deaths are classified as a child neglect fatality. This category of SIDS actually *rose* slightly in 2013. http://www.cdc.gov/sids/data.htm

[6] http://www.acco.org/about-childhood-cancer/diagnosis/childhood-cancer-statistics/

recommendations, these approaches are already bearing fruit in some communities across the country. Bringing the elements to scale and testing new theories and policies to sustain them are next steps. As a Commission, we are determined that a national strategy specifically targeted to child abuse and neglect fatalities can save thousands of children's lives each year.

FOLLOWING THIS: A 2-PAGE OVERVIEW SPREAD OF HIGH-LEVEL THEMES AND RECOMMENDATIONS

Pull Quotes that can be used in the introduction:

"It's clear that too many kids are dying and that we need to focus on what we're going to do about it. I continue to be optimistic that there is a strong bipartisan consensus in Congress to our trying to resolve this question."
–Congressman Lloyd Doggett, co-sponsor of the Protect Our Kids Act, Democrat from Texas, speaking to the Commission in San Antonio, TX, June 2014.

"We do have a chance to make a huge difference here and I think that your work is really taking steps to change the status quo and figure out what works and ultimately to give some of the most vulnerable children a real chance in this world and at a life. And that is really important work."
–Representative David Camp, co-sponsor of the Protect Our Kids Act, Republican from Michigan, speaking to the Commission in Detroit, MI, August 2014

"Every child abuse and neglect fatality represents an immeasurable loss to the family and to the community and is devastating to my workers and every health care person, every family member involved. We mourn the death of each child, but I want to learn from those deaths. I think we have an obligation to learn from those deaths."
--Judge John Specia, Commissioner, Texas Department of Family and Protective Services

"…What's next? We think that the safety science approach … creating a safety culture in child welfare agencies is what's next. It's the next frontier, if you will, in child welfare."
–Scott Modell, Deputy Commissioner, Office of Child Safety, Tennessee Department of Children's Services, speaking about a cycle of events he has seen across the country. The cycle goes like this: the child welfare budget is cut. Fast forward to high profile child deaths that lead to outrage by legislators. Commissioners and staff are fired. The legislature responds with an increase in the child welfare budget. After several years, the budget is cut and the cycle starts all over again. [**maybe just skip the cycle and use the quote, which is good all by itself.]**